STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345431	A. BUILDING _____ B. WING _____	R 02/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OUR COMMUNITY HOSPITAL	**921 JUNIOR HIGH SCHOOL ROAD SCOTLAND NECK, NC 27874**

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F 000	INITIAL COMMENTS On-site complaint investigation was conducted from 2/18/15 through 2/20/15. The exit date was changed to 2/23/15 due to an interview required and completed on 2/23/15 for the tags cited during the investigation.	F 000		
{F 279} SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on record review and staff interview the facility failed to develop a plan of care that addressed hemodialysis for 2 of 2 residents (Residents #43 & 39) receiving hemodialysis and a plan of care that addressed pressure ulcers for	{F 279}	A. Care Plans have been written for resident number 43 and number 39 addressing dialysis. 2/19/15 Minimum Data Set Coordinator(MDSC) Care plan has been written for resident	3/12/15

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed

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{F 279}	Continued From page 1 1 of 3 residents (Resident # 45) with pressure ulcers. The findings included: 1. Resident # 43 was admitted to the facility on 5/23/14. His diagnoses included chronic kidney disease requiring hemodialysis, heart failure, hypertension, diabetes, stroke with hemiplegia. The most recent Minimum Data Set (MDS), a quarterly MDS, dated 12/6/14 revealed Resident #43 was cognitively impaired and was totally dependent of staff for transfers, dressing, toileting and bathing. He required extensive staff assistance for personal hygiene. A record review revealed Resident # 43 received hemodialysis on Tuesday, Thursday and Saturday each week. A review of the resident's care plan last reviewed 12/17/14 revealed dialysis and interventions to prevent problems associated with dialysis were not addressed in the care plan. On 2/19/15 at 10:51 AM the Assistant Director of Nursing (ADON) reviewed the resident's care plan and reported there was no care plan to address the risk factors or potential complications specific to hemodialysis. 2. Resident #39 was readmitted to the facility on 9/27/13 with diagnoses which included chronic kidney disease stage IV requiring hemodialysis, hypertension, diabetes, stroke with hemiplegia and depression. A review of the quarterly Minimum Data Set (MDS) dated 11/20/14 revealed the resident was cognitively intact and required extensive assistance with transfers, toileting and personal hygiene. She required limited assistance for bed mobility and dressing. A review of the resident's care plan with team signatures date of 11/26/15 revealed the care plan did not address the resident's risk factors or potential complications specific to hemodialysis	{F 279}	number number 45 addressing pressure ulcer care and treatment. 2/20/15 MDSC. B. Per facility policy residents on dialysis will be identified at the time of admission by review of medical record information from transferring hospital/facility. A care plan for dialysis will be written within 24 hours for new dialysis admission. For in-house residents whose status changes and dialysis is required, care plan will be developed and initiated within 24 hours of start of dialysis. There are no other residents on dialysis in the facility at this time. There has been a 100% review of residents identified with pressures ulcers with care plans written and up to date for all current pressure ulcers identified. To prevent practice from happening to other residents with pressure ulcers or with the potential to develop pressure ulcer, a care plan will be written on those residents who have been identified as being at risk based on information from Braden Skin Assessment. The Braden Skin Assessment is done on every resident at the time of admission and quarterly thereafter. A score of 14 or less on the Braden identifies a resident as being at risk for skin breakdown, a care plan will be written for residents who score 14 or less. The care plan will be reviewed and updated quarterly and as needed based on results of the Braden Assessment, weekly skin assessments and visual inspection. The Director of Nursing (DON) has reviewed with the MDSC and the Staff Development	

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{F 279}	Continued From page 2 other than the care for the AV (arteriovenous) graft access site in the left arm. On 2/19/15 at 10:51 PM the ADON reviewed the resident's care plan and reported there was no care plan to address the risk factors or potential complications specific to hemodialysis. 3. Resident # 45 was admitted to the facility on 5/10/2014 with diagnoses to include stroke with hemiplegia, and dementia. A review of the resident's admission Minimum Data Set (MDS) assessment dated 5/23/2014 revealed the resident was moderately cognitively impaired, and required extensive to total assistance from staff for activities of daily living. The MDS also revealed the resident was admitted with an unstageable pressure ulcer, and was at risk for pressure ulcers. A review of the resident's most recent MDS, dated 11/23/2014, also revealed the resident had an unstageable pressure ulcer, and was at risk for pressure ulcers. The resident's Braden scale, an assessment to predict pressure sore risk, dated 11/24/2014 revealed the score was at mild risk. A review of the resident's care plan revealed no plan of care for skin integrity, skin risk or pressure ulcer. An interview was conducted with the MDS nurse on 2/20/2015 at 10:06 AM. The MDS nurse stated that the resident was admitted to the facility on 5/10/2014, with the left heel pressure ulcer. He declined to answer as to why a care plan did not address the resident's pressure ulcer.	{F 279}	Coordinator (SDC)/Treatment Nurse, to ensure that care plans have been written and are up to date. 3/5/15(DON, MDSC, SDC/Treatment Nurse) A mandatory staff meeting was conducted to review several facility policies, including policy on writing care plans with requirements. Also reviewed most recent state survey results and current 2567s and most recent plan of correction. 3/11/15, 3/12/15- Administrator, DON C.Measures which have been put into place: 1. Review of care plans for compliance of care plans written for residents with pressure ulcers and for residents receiving dialysis. To be done weekly by DON or ADON (3/5/15) 2.The MDSC and the SDC/Treatment Nurse will meet weekly to review weekly wound/skin report and to up date or write care plan for resident with pressure ulcer or skin breakdown. 3/9/15 MDSC,SDC/Treatment Nurse 3.Residents receiving dialysis will have a care plan written written within 24 hours of admission, and for in-house residents who begin dialysis a care plan will be written within 24 hours of the start of dialysis. 4. Care plans for dialysis will be reviewed/audited weekly to ensure compliance per facility policy. (3/5/15) DON, Assistant Director of Nursing D. A report of the audits of care plans for pressure ulcers and dialysis will be presented to the Quality Assurance (QA) Committee each month for a period of 3	

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{F 279}	Continued From page 3	{F 279}	months. Report will include compliance for written care plan based on Braden Assessments and treatment nurse's weekly wound/skin report. Care plans for dialysis will be reviewed weekly as well with expectation for care plans to be updated or initiated as needed. Threshold for compliance is set at 100%. Report to QA will continue for a period of 3 months and quarterly thereafter. 2/27/15 (DON,ADON)	
{F 520} SS=D	483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff. The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies. A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions.	{F 520}		3/12/15

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{F 520}	Continued From page 4 This REQUIREMENT is not met as evidenced by: Based on record review, observation and staff interview, the facility ' s Quality and Assurance Assessment committee failed to implement and monitor the action plan developed following the 12/19/2014 recertification survey in order to achieve and sustain compliance. The facility had a repeat deficiency on developing care plans (F 279). This tag is cross referred to: F 279 D: Comprehensive Care Plans - During the recertification survey of December 2014 the facility was cited : Based on staff interview, record review and observation, the facility failed to develop care plans for 2 of 2 residents (Residents #33 and #42) with behaviors, 1 of 1 resident (Resident #43) on dialysis, 1 of 4 residents (Resident #10) reviewed for nutrition, 1 of 3 residents (Resident #15) reviewed for pain and 1 of 5 residents (Resident #19) reviewed for unnecessary medications. On February 23, 2015 during a follow up survey, the facility was recited for F 279 for failure to develop a plan of care to address hemodialysis for 2 of 2 dialysis residents (Resident #43 and Resident #39), and 1 of 3 resident with pressure ulcers (Resident #45). On 2/20/2015 at 4:05 PM, an interview was conducted with the Administrator. He stated that the facility had a quality assurance committee that consisted of the medical director, director of nursing, department heads and the administrator. The committee met monthly and quarterly. The Administrator stated the committee had discussed all the tags they were cited for, including developing care plans. They had tried	{F 520}	A. For resident number 42 and resident number 39 care plans have been written addressing dialysis care and treatment. 1/19/15 (MDSC) For resident number 45, a care plan has been written addresing pressure ulcer care and treatment. 2/20/15 (MDSC) B. Corrective Action will be accomplished for those resident having potential to be affected by the same practice by: 1. Quality Assurance (QA) Committee will meet monthly to discuss problem/issues which have been identified through audits and reviews of medical records, including care plans. Once an issue of concern has been identified, thresholds of success will be set and plan of action will be implemented as necessary for quality problems 2. The identified problem(s) will be monitored monthly for a minimum of three (3) months. If the threshold is met the problem will be reviewed quarterly to ensure continued compliance. 3. For on-going problems, the committe members will appoint a sub-committe to address the issue(s) and will work toward resolution through in-service education as needed, continued chart audits and care plan reviews. 4. Directed in-service by Shannon Cambra, Director Practice Support Activities from Area L-AHEC scheduled for March 19, 2015.	

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{F 520}	Continued From page 5 to follow their plan of correction to make progress on where they were, and what had been monitored up to that point, but it was still an ongoing process. He stated the MDS nurse had re-educated the staff that they are able to change the care plan when indicated. The MDS nurse was in the process of reviewing all the care plans. The MDS nurse was now getting a copy of the incident and accident report daily so he could concerns within the care plan.	{F 520}	C. All problems identified during state survey of December 19, 2015 and re-vist survey and complaint allegation of February 18,2015 are being monitored and will be reviewed monthly for three (3) months and quarterly thereafter. 2/27/15 (DON,ADON, Administrator (Adm)) Quality concerns are identified by issues which have been addressed at weekly Risk Management Meetings, incuding care plan compliance for dialysis and pressure ulcers. (DON, ADON,Adm,MDSC,SDC,Social Worker(SW)Certified Dietary Manager(CDM),Activity Director) D. Reports will be presented at QA each month outlining the issues which have been addressed by state survey to determine whether compliance has been met. The QA committe will review data obtain from quality indicator reports generated from information from the MDS and data entered by the Abaqis Quality Management System (a system which replicates the Quality Indicator Survey Methodology and annual survey/compliant investigation.2/27/25	